STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555795	A. BUILDING _____ B. WING _____	08/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VETERANS HOME OF CALIFORNIA -	700 EAST NAPLES COURT CHULA VISTA, CA 91911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(x5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of California Department of Public Health during a Re-Certification survey. Representing California Department of Public Health: Manny Dumangas, HFEN Naomi Russell, HFEN Margaret Hillard, HFEN Elna Ramos, HFEN Census: 147 Resident Sample Size: 24	F 000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal Law.	
F 164 SS=D	483.10(e), 483.75(i)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside of the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1… The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: based on observation, interview, and policy review, the facility failed to ensure that the patient's right to personal privacy and confidentiality was protected when signs involving the type of care to be provided for 1 unsampled resident (Resident A) were observed posted on the wall above his headboard. Findings: During an observation on 8/18/09 at 1:45pm in room 1303 of unit 1100, it was observed that two signs involving the type of care to be provided for Resident A were posted on the wall above his headboard. The first sign indicated, "*Attention* AM and PM shift please put [Resident A] in the "Center" of the bed all the time…" The second sign indicated, "*for meals in bed: 1)HOB (Head of Bed) at 90°. 2) Resident seated in MIDLINE (0 leaning) *use pillows under BOTH arms for support. 3) Place high side of scoop plate to his RIGHT." During an interview with the Licensed Vocational Nurse on 8/18/09 at 1:50pm in unit 1100, she stated that she had given medications in the pod. She also stated, "I didn't know that it was there (referring to the signs observed)."	F 164	It is the policy of the Veterans Home to keep confidential all information contained in the resident's records. Nursing staff immediately checked all resident rooms. No other residents were affected by this deficient practice. In-services were conducted for all therapists by the Chief, Restorative Services. The therapists were instructed that when giving an in-service on a particular orthotic device, positioning, safety precautions, etc., they will provide written instructions / handouts. This will be posted inside the closet door. Also, specific instructions will be written on the resident's care plan. If the instructions require pictures or photos, then these will be in the care plan as well. Environmental rounds will be conducted monthly on each SNF nursing unit in an effort to identify any variances to this policy. Variances will be reported to the Quality Assurance Committee.	9/17/09

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F 164	Continued From page 2… On 8/18/09 at 2:30pm, an interview with the Director of Nursing (DON) was conducted. The DON stated, "The signs should have been kept in the closet. Staff were instructed and meeting was held. Staff were even instructed to go into each room to remove the signs and put is away in the closet." The facility policy and procedure titled "Confidentiality of Medical Information "with a revision date of 3/23/09 was reviewed. The review indicated, "PROCEDURE: 1. HANDLING OF CONFIDENTIAL MEDICAL INFORMATION. A. Medical information contained in the resident's medical record is confidential and shall be disclosed only to authorized persons with the resident's consent."	F 164		
F 278 SS=D	483.20(g) – (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and	F 278		

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F 278	Continued From page 3… false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each resident received and accurate assessment when 1 of 24 sampled residents (Resident 7) was documented to have a fall in the MDS (Minimum Data Set) when there was no evidence that the resident had an incident of fall. Findings: On 8/18/09 at 3:00pm, a clinical record review of Resident 7 was conducted. The review indicated in the MDS with an assessment reference date of 7/12/09 under section J4 – accidents, that Resident 7 had an incident of fall within the past 30 days. On 8/19/09 at 10:45am, a review of the Nursing Progress Notes dated 6/12/09 was conducted. The review indicated, "…During transfer with two CNAs (Certified Nursing Assistants) assistance from powered wheelchair to his regular wheelchair, resident was eased down to the floor because the wheelchair rolled back. Assessed, Range of motion within normal range. RUE/LUE(Right Upper Extremity/Left Upper Extremity) with very limited ROM (Range of Motion) due to old CVA (cerebrovascular incident). No complaint of pain/discomfort. No skin tear no skin	F 278	It is the policy of the Home to ensure that each resident receive an accurate assessment reflecting the resident's status. Resident 7 was not clinically impacted by the deficient practice. The Standards Compliance Coordinator reviewed all incident reports for the last 6 months and no other resident was affected by the same deficient practice. MDS 2.0 training was conducted at the Veterans Home for all Interdisciplinary Team (IDT) Members on September 8, 2009 by Patti Garibaldi, educational consultant of Consonus Healthcare. Emphasis was placed on Section G of the MDS, accidents and proper coding of fall. The Veterans Home policy on falls was revised on September 14, 2009 to include the OBRA definition of fall. The staff were in-serviced on the new fall policy on September 15, 2009 and September 17, 2009. The MDS coordinators will follow the system in place for accidents specially falls as discussed in the fall committee. Clinical disagreement will be resolved with each care conference by the IDT (interdisciplinary team) before the MDS coordinator certifies and transmit the MDS. The unit SRNs (Supervising Registered Nurse) will monitor compliance every week with each care conference and report variances to the QA committee.	9/17/09

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F 278	Continued From page 4… discoloration." During an interview with the Charge Nurse in unit 700 on 8/19/09 at 9:55am, she reviewed the clinical record of Resident 7 and was unable to find documentation of any incident of fall with in the past 30 days from the assessment reference date (7/12/09) indicated in the MDS. On 8/19/09 at 11:25am, an interview with the MDS nurse was conducted. The MSDS nurse stated, "My justification is that when the patient is down on the floor, it's considered a fall." She also stated, "My failure was to clarify with the team. The MDS nurse further stated that, "I read the nursing progress note as if the patient fell down on the floor, reason why it was coded as a fall." On the same date at 11:48 am, an interview with the Supervising Registered Nurse (SRN) of unit 700 was conducted. The SRN stated, "there was no fall on 6/12/09. The resident was assisted on the floor by two CNAs because the wheelchair was rolling back and to provide safety for the resident and staff."	F 278		
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to implement a developed care plan	F 282		

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F 282	Continued From page 5 by the IDT (Interdisciplinary Team) to place tab alarm on bed and chair, when resident is on it, for fall prevention and further failed to carry out a physician's order for 1 of 24 sampled residents. (Resident 10) Findings: 1. Resident 10 has diagnoses that included Cancer of the Prostate (metastatic), Hypertension, Airway Obstruction and Diabetes Mellitus. On 6/8/09, Resident 10 went for oncology appointment. The oncologist ordered Resident 10 to return to the clinic for follow-up by 8/17/09, with laboratory test for PSA (Prostate Specific Antigen) level, CBC (Complete Blood Count) with differential, Creatinine level and Liver function test. On 8/18/09 at 9 a.m. during clinical record review, there was no written evidence to indicate that Resident 10 was taken to the oncology clinic follow-up appointment nor were the bleed test samples was drawn and collected as ordered. On the same day at 11 a.m. during an interview with the unit charge staff and the MDS (Minimum Data Sheet) coordinator, both stated that Resident 10 did not go to the oncology clinic follow-up appointment nor were the laboratory test done. 2. On 8/18/09 at 10 a.m., a clinical record review of Resident 10 indicated that he fell on four occasions from 6/13/09 to 7/19/09. The care plan on fall prevention was updated on 6/13/09. The update included to use tab alarm on bed and wheelchair. Nursing Progress Notes dated 6/14/09, 6/24/09 and 7/19/2009 indicated that	F 282	It is the policy of the Veterans Home to develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, physical, mental and psychosocial needs. Resident 10 was not medically impacted by the deficient practice. Follow-up laboratory tests were immediately completed on August 19 and August 20, 2009. All outside medical appointments for the last 3 months were reviewed by the SRNs of the units and no other resident was affected by the same deficient practice. A follow up appointment for the Resident 10 was set up for September 22, 2009. Mandatory in-service on Documentation and Comprehensive Care Planning was conducted on September 15, 2009 and September 17, 2009 attended by all licensed nurses. The policy on Documentation and Confidentiality and Care Planning were reviewed with the Staff on same dates. A new process for follow-up appointments of outside medical referrals was put into place and all licensed nurses and OAs (office assistants) were in-serviced on September 15, 16, and 17, 2009. Compliance will be monitored by the SRNs weekly x 3 months and variances will be reported to the QA committee.	9/17/09

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F 282	Continued From page 6… resident 10 was found by staff on these occasions lying on the floor by the bed or by the wheelchair. There were no documented evidence that the tab alarm sounded and the staff responded to the alarm, to check resident 10. On the same day at 11 a.m., during an interview with the unit charge staff, she stated that Resident 10 on occasions will remove the tab alarm from the bed or wheelchair. There was no evidence to indicate that this problem was addressed during post fall assessment.	F 282		
F 445 SS=D	483.65(c) INFECTION CONTROL – LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and document review, the facility failed to handle and transport linens to prevent the spread of infection on two different units of the facility. Findings: 1. On 8/18/09 at 7:15 a.m., on Unit 300, a Certified Nursing Assistant (C.N.A.) was observed coming out of a room with soiled linen and not wearing gloves. There was not a linen cart outside the resident's room. The C.N.A. looked around and then went back into the same room with the soiled linen. She placed the soiled linen on top of a trash can in the resident's room. She then put on gloves without washing her hands, picked up the soiled linen, and took it out of the resident's room. She opened a door to a dirty	F 445	It is the policy of the Veterans Home to ensure safe handling of linens to prevent the spread of infection. CNAs are reminded to use gloves whenever handling soiled linen and to wash their hands after removal of gloves. A mandatory in-service on handling soiled linen was completed by the Infection Control Specialist and the DSD on September 16, 2009. The in-service included Licensed nurses to remind and supervise their CNAs on their shifts to	9/16/09

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F 445	Continued From page 7 linen closet and placed the soiled linen in a dirty laundry cart. The C.N.A. was interviewed at this time, and she stated, "I just forgot to put gloves on; we should always wear gloves when we handle dirty linen." 2. On 8/19/09 at 4:30 p.m., on Unit 700 a C.N.A. was observed coming out of a resident room with soiled linen and not wearing gloves. The C.N.A. carried the bundle of soiled linen from on end of the unit to the other, where she placed the soiled linen in a laundry cart, and then took the cart pass the nursing station to a dirty laundry closet. The C.N.A. walked back to a different resident room on the unit and washed her hands. An interview was conducted at this time with the C.N.A., who stated, "We are supposed to wear gloves at all times, I just forgot to put them on and I should have a laundry cart outside of room". An interview was conducted with facility administrative staff on 8/19/09 at 4:10p.m., and stated that staff are all taught to wear gloves when handling soiled linen. On 8/19/09 the facility Policy and Procedure for Infection Control was reviewed. The Policy and Procedure indicated, "PURPOSE: To provide guidelines in the handling of clean and soiled linen, including resident's personal clothing. II SOILED LINEN C. Hands shall be washed after removal of gloves or after handling soiled linen".	F 445	Continued From page 7… ensure that gloves are worn when handling soiled linen. The Infection Control Specialist will perform random checks to ensure compliance. Trends will be reported to the QA Committee for further actions as needed.	
F 493 SS=D	483.75(d)(1)-(2) GOVERNING BODY The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing	F 493		

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F 493	Continued From page 8 and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that the following policies titled, 1. “Disposition of Non-control Drugs” 2.”Infection Control, Food Safety and Sanitation” 3.”Infection Control” and 4.”Post Discharge Plan of Care” were implemented as written. Findings: 1. On 8/18/09 at 9:30 a.m. during medication storage inspection, a 90cc (cubic centimeter) bottle of Delsym cough syrup with an open date of 7/13/08 was found. On the same day at 2:00p.m., when asked where the Delsym medication was, the unit charge nurse stated that the medication Delsym was emptied in to the “hopper” (drain). She further stated, that discontinued medications on bubble packs are sent back to the pharmacy to be incinerated and the liquids are poured out into the “hopper”. On 8/19/09 at 9 a.m. when asked how discontinued liquid medication are disposed, the Unit Supervisor stated that all discontinued medications are sent back to pharmacy in a designated box.	F 493	The Veterans Home has a governing body responsible for establishing and implementing policies regarding the management and operation of the Home. 1. Mandatory in-service on the policy and procedure for disposition of non-controlled drugs was conducted on September 15th and 17th attended by all licensed nurses. Failure to follow the policy and procedure of the disposition of non-controlled drugs will result in counseling. The licensed nurse with the deficient practice was counseled by her unit manager on August 20, 2009. Compliance will be monitored by the unit SRN x 6 months and variances will be reported to the QA committee.	9/17/09

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F 493	Continued From page 9 On the same day at 12:30 p.m., review of the facility policy titled, "Disposition of Non-controlled Medications" found that Procedure: "A. Non-controlled used blister packs and Non-controlled liquid medications will be placed in the EXP Pharmaceutical waste container in the nursing unit's medication room. 2. On 8/17/09 at 4:00 p.m. during initial tour of the main kitchen in the walk-in freezer, a box of frozen food was found inappropriately stored on the freezer floor. Additional boxes of frozen food were also observed inappropriately stored on shelves above the 18 inches clearance from the ceiling. When asked, the dietary staff stated that food items should be stored on shelves above the floor. He further stated that it is acceptable to store items greater than 18 inches below the ceiling clearance as long as it does not block the water sprinklers. On 8/18/09, review of the facility policy titled, "Infection Control, Food Safety and Sanitation" revealed that under "Procedure V.R. All food, paper and equipment items shall be stored on shelves > 6 inches off the floor and > 18 inches from the ceiling or light fixtures". 3. On 8/18/09 at 7:15 a.m., on Unit 300, a Certified Nursing Assistant (C.N.A.) was observed coming out of a room with soiled linen and not wearing gloves. There was not a linen cart outside the resident room. The C.N.A. looked around and then went back into the same room with the soiled linen. She placed the soiled linen on top of a trash can in the resident room. She then put on gloves without washing her hands, picked up the soiled	F 493	It is the policy of the Veterans Home to store, prepare, distribute and serve food under sanitary conditions. 2. All products must be stored on shelves $\geq$ 6 inches off the floor and $\geq$18 inches from the ceiling or light fixtures. The Dietetic Service Staff Members were immediately instructed on the proper food storage procedures. The product on the floor and the items less than 18in. from the ceiling were immediately removed. A mandatory in-service will be conducted for all Food Service Workers on proper food storage and handling procedures on 09/23/09. The Dietetic Service Manager or designee shall oversee the procedures to ensure compliance. The Director of Clinical Dietetics and Nutrition Services will perform random checks as well as an in depth monthly kitchen inspection and report variances to the QA Committee. 3 & 4. CNAs are reminded to use gloves whenever handling soiled linen and to wash their hands after removal of gloves. An mandatory in-service on handling soiled linen was conducted by the Infection Control Specialist and the DSD on September 16, 2009. The in-service included Licensed nurses to remind and	9-23-09 9-16-09

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F 493	Continued From page 10 linen, and took it out of the resident's room. She opened a door to a dirty linen closet and placed the soiled linen in a dirty laundry cart. The C.N.A. was interviewed at this time, and she stated, "I just forgot to put gloves on, we should always wear gloves when we handle dirty linen." 4. On 8/19/09 at 4:30 p.m., on Unit 700 a C.N.A. was observed coming out of a resident's room with soiled linen and not wearing gloves. The C.N.A. carried the bundle of soiled linen from on end of the unit to the other, where she placed the soiled lien in a laundry cart, and then took the cart pass the nursing station to a dirty laundry closet. The C.N.A. walked back to a different resident's room on the unit and washed her hands. An interview was conducted at this time with the C.N.A., who stated, "We are supposed to wear gloves at all times, I just forgot to put them on and I should have a laundry cart outside of room". An interview was conducted with facility administrative staff on 8/19/09 at 4:10 p.m., and stated that staff are all taught to wear gloves when handling soiled linen. On 8/19/09 the facility Policy and Procedure for Infection Control was reviewed. The Policy and Procedure indicated, "PURPOSE: To provide guidelines in the handling of clean and soiled linen, including resident's personal clothing. II SOILED LINEN B. Soiled linen shall be placed in the soiled linen hampers located in each resident pod. C. Hands shall be washed after removal of gloves or after handling soiled linen."	F 493	Continued from page 10… supervise their CNAs on their shifts to ensure that gloves are worn when handling soiled linen. The Infection Control Specialist will perform random checks to ensure compliance. Trends will be reported to the QA Committee for further actions as needed.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VETERANS HOME OF CALIFORNIA -	700 EAST NAPLES COURT CHULA VISTA, CA 91911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER's PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ,CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 493	Continued From page 11 5. On 8/19/09 at 3:00 p.m., a review was done of the closed medical record of Resident 18, who was discharged on May 12, 2009. A review of the Resident's Post discharge Plan dated 5/12/09 failed to show that the document had been signed and dated by the resident. An interview was held on 8/19/09 at 3 p.m. with the Director of Nurses who stated that "The staff are aware that all documentation of the transfer forms during a transfer have to be properly filled out." This included having a resident who is being discharged sign and date the Resident Post Discharge Plan. Review of facility Transfer or Discharge Policy which indicates under "Notice before transfer or discharge: C. The Charge Nurse must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This preparation and orientation should be documented in the resident's medical record." The facility failed to follow the policy and procedure for Transfer/Discharge. The Patient did not sign his post discharge plan.	F 493	5. Mandatory in-service on the policy and procedure for "Transfer or Discharge" was conducted for all licensed nurses on September 15 and 17, 2009. Compliance will be monitored by the unit SRN with each transfer or discharge and variances will be reported to the QA committee.	9-17-09